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## PRESENTING THE DIAGNOSIS OF FUNCTIONAL ILLNESS

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In lecturing recently to medical residents on "Psychotherapy", I said among other things that when the doctor considers the patient's primary disorder to be an emotional illness, he should so inform the patient honestly. Later, I read an article by Hart<sup>1</sup>, who writes: "There is no evidence to show that patients with cardiac neurosis really fear heart disease; on the contrary, their over-all behavior suggests that they need and seek a tangible organic defect, perhaps as a rationalistic lesser-evil defense against suspected mental illness. In these patients, reassurance that the heart is sound is not only ineffective but commonly aggravates anxiety and other symptoms." Hart does not tell the patient his honest opinion that heart disease is absent, but instead ". . . hasty diagnoses were frowningly deplored, and a truthful, but indefinite statement was made: 'I don't know yet what the whole trouble is.' " Return visits were made, keeping the emphasis on re-examination, on physical complaints, on avoidance of probing into personality factors, and in exhibiting "genuine human interest in the patient as a person."

Hart's statement and his technique are at variance with the procedure which I, a psychiatrist, had advocated; yet I could see that his position is sound. Perhaps there is some truth in what each of us is saying, and our difference occurs because our viewpoints reflect our different specialties.

Hart is talking about what we psychiatrists call "resistance." In all psychotherapy, interpretations (truth as the doctor sees it) may be misunderstood and rejected by the patient, often with resentment—not because the interpretations are incorrect but simply because, as the layman says, the truth hurts. Judgment is required to determine how rapidly to give the interpretations, and how to give them with the least discomfort to the patient. It is better that he learn a little of the truth which he can accept and use constructively, than that he hear it all and accept none of it. Nevertheless, however cautiously, slowly, gently we approach the patient's resistances, it is still our task to approach them, test them, to keep trying patiently to tell him a little more of the truth (as we see it) about himself.

If I have failed to apply this knowledge I already had about the general subject of resistance to the question of how a diagnosis of functional disease is to be presented to the patient, it is because I did not realize how strong a resistance patients in general have to that diagnosis. This came about because of two features of my specialized position as psychiatrist:

1. When the patient comes to the psychiatrist, the mere fact that he is there at all is an indication that he has already partially accepted the idea of emotional causation of his disorder. The fact of his being there may well represent a good deal of effort and explanation and persuasion on the part of the internist who sent him.
2. The internist, not the psychiatrist, bears the responsibility if perchance his opinion that no physical disease is present is later found to be wrong. If the internist has in addition expressed an opinion that the cause of the symptoms is in the emotional life, the patient will be doubly bitter, for he will think that the doctor added insult (by calling it psychogenic) to the injury (of overlooking the physical disease). Such experiences, from which the psychiatrist is largely spared, teach the internist first-hand to have great respect for the patient's resistance to the suggestion that his illness is emotional.

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There is then good reason for the diagnostician to approach that resistance gingerly. I consider the technique Dr. Hart uses, that of giving the patient a "truthful but indefinite" answer, to be all right—as far as it goes. However, I would dislike to think that it is as far as the internist can and should go with the majority of his patients. Most patients can accept a little more of the truth than that; furthermore, they will press the doctor, after the first two or three visits, for more definiteness in diagnosis. The technique I was advocating is at the opposite end of the scale from Hart's technique, and I now see it is too blunt for the internist to use, at least just as soon as the diagnostic studies are completed. There are, however, some in-between stages which can be listed. I believe it is the duty of the internist to choose how far along these in-between stages he should conduct each particular patient—depending both on his opinion of the patient's needs and the patient's capacity to accept these successive fragments of the truth. If the patient needs and can take it, the doctor should no more flinch from the unpleasantness of giving it than he flinches from giving a painful injection which the patient needs and can take. In general, the unpleasantness can be largely avoided if the doctor merely waits until the patient himself brings up the next fragment of the truth, and the doctor merely affirms it.

One may begin where Hart does: I don't know yet what the whole cause of your symptoms is; next, the cause of your symptoms is malfunctioning of certain organs; then, the malfunctioning is caused by nervous or emotional tension; then, nervous tension is caused by poor mental and physical hygiene, and/or current stressful life situations, and/or unfortunate circumstances in your past life over which you had no control. If the internist does carry the patient successfully to this point of self-knowledge, he will have attained all I had in mind originally, in advocating that the doctor honestly inform the patient of his opinion that the primary disorder is an emotional illness.

It is beyond the province of the internist to go into the reasons, the causes for these things: the patient's apparent inability to correct his poor mental and physical hygiene by resolving to do (i.e., to learn how to relax and to follow good health rules); the patient's apparent inability to correct his current life stresses, to escape from them, or to tolerate them with equanimity; and the fact that the patient himself has played some part in creating both the past and present unfortunate circumstances of his life. In general, the reason for these things lies in the fact that his behavior, which is now so troublesome to him, once had a useful purpose. He once "wanted" to behave in a somewhat similar way to gain an emotional satisfaction (such as the love of his mother); and now when he cannot find, on the adult level, adequate emotional satisfaction, he regresses to behaviour which gives him, on an immature level, a somewhat similar substitute satisfaction. In short, there is still a part of him which "wants" to behave as he does. We might say, the trouble with us is ourselves. This is a nice phrase anyone can readily apply to himself—in general; but the resistance is so great when we start applying it in particular, that an entire medical specialty, Psychiatry, has had to arise to try to deal with it.

**SUMMARY**—If your opinion is that the patient has no serious physical disease, and his disorder is primarily emotional, you need not immediately tell him these opinions fully and frankly. Many patients have a strong resistance to accepting these particular opinions, and it is better to tell him a little of the truth which he can accept, than all of it which he cannot accept.

A number of means of disclosing these opinions partially, in a step by step manner, are mentioned.

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